United States Department of Labor
Employees' Compensation Appeals Board

J.D., Appellant	)	
	)	**Docket No. 17-1470**
and	)	**Issued: December 15, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Danville, VA, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 26, 2017 appellant, through counsel, filed a timely appeal from a May 3, 2017 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the claim.

ISSUE

The issue is whether appellant has established more than 10 percent permanent impairment of the left upper extremity, for which she previously received a schedule award.

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

FACTUAL HISTORY

OWCP accepted that on or before October 20, 2009 appellant, then a 38-year-old letter carrier, sustained a shoulder and upper arm sprain due to repetitive trauma from carrying a mail satchel on her left shoulder.

Appellant was first followed by Dr. Gahear F. Hamlor, an attending family practitioner, who diagnosed a left shoulder sprain and noted a history left carpal tunnel syndrome[3] on February 19, 2010. In a March 4, 2010 report, Dr. Hamlor attributed appellant's symptoms to carrying a mail satchel on her left shoulder.[4] Appellant remained off work.[5] OWCP paid appellant wage-loss compensation for total disability beginning February 27, 2010. Apart from a very brief return to work in early May 2010, appellant remained off work. OWCP paid wage-loss compensation through October 22, 2011. Appellant remained under medical treatment.

Dr. Michael Kyles, an attending Board-certified orthopedic surgeon, treated appellant beginning March 2010 for left shoulder impingement. A steroid injection was ineffective in relieving appellant's symptoms. In an October 1, 2010 report, Dr. Kyles noted that appellant obtained significant relief of her shoulder symptoms with trigger point injections administered by a neurologist.

In a February 7, 2011 report, Dr. William C. Andrews, Jr., an attending Board-certified orthopedic surgeon, administered a left subacromial injection. Appellant participated in physical therapy in August to November 2011. Dr. Andrews provided periodic progress notes through December 2011.[6]

Appellant returned to full-time modified duty on December 20, 2011. She stopped work on January 17, 2012 due to increased left arm pain, and resumed work on January 25, 2012. Appellant worked part-time modified duty in February and early March 2012. OWCP issued appropriate compensation for work absences.

On July 13, 2012 Dr. Andrews administered a steroid injection to address left epicondylitis. August 15, 2012 EMG/NCV studies showed moderate median nerve neuropathy at the wrist without active denervation.

---

[3] June 26, 2008 and August 12, 2010 electromyography/nerve conduction velocity (EMG/NCV) testing demonstrated bilateral carpal tunnel syndrome.

[4] A magnetic resonance imaging (MRI) scan of the left shoulder performed on March 11, 2010 demonstrated probable mild impingement.

[5] Appellant participated in physical therapy in March and April 2010.

[6] To assess the nature and extent of appellant's left shoulder condition, on April 27, 2011, appellant obtained a second opinion from Dr. J. Wayne Keeling, a Board-certified orthopedic surgeon. Dr. Keeling opined that appellant remained totally disabled for work due to significant left rhomboid and upper trapezius pain, caused by work factors. A June 23, 2011 functional capacity evaluation obtained by OWCP demonstrated appellant's capacity to perform full-time light-duty work.

Appellant resumed part-time modified work on May 21, 2012. OWCP paid appellant wage-loss compensation for the remaining hours.

In a July 5, 2012 report, Dr. Andrews diagnosed left subacromial bursitis. He opined in September 12, 2012 and March 11, 2013 reports that appellant had occupationally-related left carpal tunnel syndrome, and required a left carpal tunnel release and excision of the left distal clavicle.

Appellant stopped work on December 14, 2013. She filed a claim for recurrence of disability (Form CA-2a) on January 24, 2014. Appellant remained off work. Dr. Andrews provided a February 14, 2014 report, explaining that the left shoulder condition worsened the carpal tunnel syndrome, which in turn aggravated subacromial bursitis. He continued to hold appellant off work.

In a May 1, 2014 decision, OWCP denied appellant's claim for a recurrence of disability commencing December 14, 2013, finding that the medical evidence of record was insufficient to support a worsening of the accepted shoulder sprain. On May 9, 2014 counsel requested a telephone hearing before a representative of OWCP's Branch of Hearings and Review.[7]

On August 5, 2014 Dr. Andrews performed an open left distal clavicle excision and left carpal tunnel release. He removed one centimeter of "very significantly arthritic" bone from the distal end of the left clavicle. Appellant underwent physical therapy through November 2014 and Dr. Andrews provided progress notes. In a January 7, 2015 note, Dr. Andrews opined that appellant had not attained maximum medical improvement.

OWCP paid appellant wage-loss compensation from December 31, 2014 through August 6, 2015.

By decision dated March 2, 2015, an OWCP hearing representative affirmed OWCP's May 1, 2014 decision, finding that the medical evidence of record did not establish a significant worsening of the accepted left shoulder sprain on or about December 14, 2013, when she had stopped work.

In a May 1, 2015 report, Dr. Andrews ordered a repeat MRI scan of the left shoulder to ascertain the cause of appellant's increasing pain and immobility. He found that she attained maximum medical improvement as of July 17, 2015.

On September 12, 2015 appellant claimed a schedule award (Form CA-7).

In a September 28, 2015 letter, OWCP notified appellant of the additional evidence needed to establish her claim, including a report from her attending physician supporting that she had attained maximum medical improvement, the diagnosis on which the permanent impairment is based, a detailed description of the permanent impairment, and an impairment rating calculated according to the sixth edition of the American Medical Association, *Guides to the*

[7] A telephone hearing was held on December 11, 2014.

Evaluation of Permanent Impairment (hereinafter, A.M.A., *Guides*).[8] Appellant was afforded 30 days to submit such evidence.

By decision dated October 29, 2015, OWCP denied appellant's schedule award claim, finding that the medical evidence of record did not establish ratable permanent impairment of a scheduled member of the body.

On November 4, 2015 counsel requested a telephone hearing before a representative of OWCP's Branch of Hearings and Review. Appellant submitted new medical evidence.

Dr. Joshua B. Macht, an attending Board-certified internist, provided an October 15, 2015 report reviewing appellant's history of injury and treatment. He opined that appellant had attained maximum medical improvement on or before December 31, 2014. On examination, Dr. Macht found slight weakness of the left shoulder, mild pain with resisted motion, a positive Tinel's sign, and tenderness to palpation of the ventral side of the left wrist. He observed the following range of left shoulder motion: 120 degrees flexion; 45 degrees extension; 130 degrees abduction; 40 degrees adduction; 50 degrees external rotation; "normal" internal rotation. Dr. Macht noted that each range of motion (ROM) measurement was obtained after at least three trials to ensure accuracy. He obtained grip strength measurements at 34 kilograms on the right and 18 kg on the left. Dr. Macht diagnosed status-post left distal clavicle resection, and status post left carpal tunnel release. Referring to Table 15-5 of the A.M.A., *Guides*,[9] he assessed a grade 1 diagnosis-based impairment (DBI) rating Class of Diagnosis (CDX) of the left shoulder for acromioclavicular joint injury or disease with open distal clavicle resection. Dr. Macht found a grade 4 modifier for Functional History (GMFH) due to a *Quick*DASH score of 86, which he disregarded as it was more than two grades higher than the CDX. He found nine percent permanent impairment of the left arm according to Table 15-34 due to limited motion, equaling a grade 1 modifier for Physical Examination (GMPE). There was no applicable modifier for Clinical Studies (GMCS) as they were "used to define her impairment class."

Regarding the left wrist, Dr. Macht found a grade 1 CDX for carpal tunnel syndrome, a GMCS of 1, a GMFH of 3, and a GMPE of 3. Applying the net adjustment formula of (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX), or (3-1) + (3-1) + (1-1), he calculated a grade modifier of 2, equaling percent impairment of the left arm. Dr. Macht concluded that appellant had 10 percent permanent impairment of the left upper extremity due to her left shoulder injury, and an additional 5 percent permanent impairment due to left carpal tunnel syndrome. He combined these values to find a total of 15 percent permanent impairment of the left arm.

By decision dated May 13, 2016, an OWCP hearing representative remanded the case to OWCP for additional development regarding whether appellant had a ratable impairment of the left upper extremity.

[8] A.M.A., *Guides* (6th ed. 2009).

[9] Table 15-5, page 401-05 of the sixth edition of the A.M.A., *Guides* is titled "Shoulder Region Grid: Upper Extremity Impairments."

An OWCP medical adviser reviewed the medical evidence of record and an updated statement of accepted facts on January 8, 2016. He opined that the accepted work factors resulted in 10 percent permanent impairment to the left arm due to the left shoulder condition based on the distal clavicle resection according to Table 15-5. The medical adviser asserted that OWCP should disregard Dr. Macht's finding of additional impairment of the left arm due to restricted left shoulder motion, as ROM was used primarily as a factor in calculating GMPE.

By decision dated June 2, 2016, OWCP issued appellant a schedule award for 10 percent permanent impairment of the left upper extremity. The period of the award, equivalent to 31.20 weeks of compensation, ran from December 31, 2014 to August 6, 2015.

Appellant separated from the employing establishment, effective June 27, 2016.

On September 8, 2016 OWCP administratively combined appellant's claims, File Nos. xxxxxx076 and xxxxxx789, with File No. xxxxxx076 serving as the master file.

In a June 13, 2016 letter, appellant requested a hearing before a representative of OWCP's Branch of Hearings and Review. At the hearing, held February 16, 2017, counsel asserted that Dr. Macht's reports established 15 percent permanent impairment of the left upper extremity. He also contended that the case should be remanded to OWCP to address whether appellant's condition should be assessed using the DBI or the ROM method.

Appellant provided periodic treatment notes from Dr. Andrews dated from July 19, 2016 to January 23, 2017. Dr. Andrews did not address the issue of permanent impairment in these reports.

By decision dated May 3, 2017, OWCP's hearing representative affirmed OWCP's June 2, 2016 decision, finding that OWCP's medical adviser properly applied the appropriate portions of the A.M.A., *Guides* in finding 10 percent permanent impairment of the left upper extremity. She further found that there was no probative medical evidence of record establishing a greater percentage of permanent impairment.

LEGAL PRECEDENT

Section 8149 of FECA delegates to the Secretary of Labor the authority to prescribe rules and regulations for the administration and enforcement of FECA. The Secretary of Labor has vested the authority to implement the FECA Program with the Director of OWCP.[10] Section 8107 of FECA sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[11] FECA, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice under the law, good administrative practice requires the use of uniform standards applicable to all claimants. Through its

[10] *See* 20 C.F.R. §§ 1.1-1.4.

[11] For a complete loss of use of an arm, an employee shall receive 312 week's compensation. 5 U.S.C. § 8107(c)(1).

implementing regulations, OWCP adopted the A.M.A., *Guides* as the appropriate standard for evaluating schedule losses.[12]

The sixth edition of the A.M.A., *Guides* was first printed in 2008. Within month of the initial printing, the A.M.A. issued a 52-page document entitled "Clarification and Corrections, Sixth Edition, *Guides to the Evaluation of Permanent Impairment*." The document included various changes to the original text, intended to serve as *erratum*/supplement to the first printing of the A.M.A., *Guides*. In April 2009, these changes were formally incorporated into the second printing of the sixth edition.

As of May 1, 2009, schedule awards are determined in accordance with the sixth edition of the A.M.A., *Guides* (2009).[13] The Board has approved the use of OWCP of the A.M.A., *Guides* for the purpose of determining the percentage loss of use of a member of the body for schedule award purposes.[14]

ANALYSIS

The issue on appeal is whether appellant sustained greater than 10 percent permanent impairment of the left upper extremity, for which she previously received a schedule award.

The Board finds that this case is not in posture for decision.

The Board has found that OWCP has inconsistently applied Chapter 15 of the sixth edition of the A.M.A., *Guides* when granting schedule awards for upper extremity claims. No consistent interpretation had been followed regarding the proper use of the DBI or the ROM methodology when assessing the extent of permanent impairment for schedule award purposes.[15] The purpose of the use of uniform standards is to ensure consistent results and to ensure equal justice under the law to all claimants.[16] In *T.H.*, the Board concluded that OWCP physicians were at odds over the proper methodology for rating upper extremity impairment, having observed attending physicians, evaluating physicians, second opinion physicians, impartial medical examiners, and district medical advisers use both DBI and ROM methodologies interchangeably without any consistent basis. Furthermore, the Board observed that physicians interchangeably cited to language in the first printing or the second printing when justifying use of either ROM or DBI methodology. Because OWCP's own physicians were inconsistent in the

[12] 20 C.F.R. § 10.404. *See also Ronald R. Kraynak*, 53 ECAB 130 (2001).

[13] *See* Federal (FECA) Procedure Manual, Part 3 -- Medical, *Schedule Awards*, Chapter 3.700, Exhibit 1 (January 2010); Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Award and Permanent Disability Claims*, Chapter 2.808.5a (February 2013).

[14] *Isidoro Rivera*, 12 ECAB 348 (1961).

[15] *T.H.*, Docket No. 14-0943 (issued November 25, 2016).

[16] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

application of the A.M.A., *Guides*, the Board found that OWCP could no longer ensure consistent results and equal justice under the law for all claimants.[17]

In order to ensure a consistent result and equal justice under the law for cases involving upper extremity impairment, the Board will set aside the May 3, 2017 decision. Utilizing a consistent method for calculating permanent impairment for upper extremities applied uniformly, and after such other development as may be deemed necessary, OWCP shall issue a *de novo* decision on appellant's claim for an upper extremity schedule award.[18]

CONCLUSION

The Board finds that this case is not in posture for decision.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated May 3, 2017 is set aside and the case remanded for further action consistent with this decision of the Board.

Issued: December 15, 2017
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board

[17] *Supra* note 14.

[18] *See* FECA Bulletin No. 17-06 (issued May 8, 2017).